

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/02/2019
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS This report is the result of Complaint Investigations 3628059, 36307- 18,3643660, 3647682, 3647755, 3649130, and 3653197 conducted at Fircrest School Program Area Team A on 04/04/19, 04/10/19, 05/08/19, 05/23/19, 05/30/19, 06/06/19, 06/24/19 and 07/02/19. Failed provider practice was identified and citations were written. The survey was conducted by: Arika Brasier Olivia St. Claire The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-3215	W 000	<div style="text-align: center;"> <p>RECEIVED</p> <p>JUL 26 2019</p> <p>Residential Care Services ICF/IID Program</p> </div>		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the rights of one of one Sample Clients (Client #1) were protected when the	W 125			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Supt.

(X6) DATE

7/26/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 125	<p>Continued From page 1</p> <p>the facility allowed staff to restrain Client #1 for a blood draw without obtaining written consent. This failure resulted in a violation of Client #1's due process rights.</p> <p>Findings included ...</p> <p>Record review of the facility's 5-Day Investigation, dated 04/02/19, showed that a blood draw was completed by the Registered Nurse (RN) on 03/23/19 at 6:20 AM. The RN statements showed that the first attempt at the blood draw was not successful because Client #1 was uncooperative and kept pulling his hand away. A second attempt was made shortly thereafter. During the second attempt Client #1 laid on his bed while an Attendant Counselor held his upper left shoulder down, another nurse held his left upper arm and left wrist down, and the RN held his left hand with her thumb on top of his left middle finger up to the knuckle. At 2:40 PM, staff discovered that Client #1's left hand was swollen. On 03/25/19 Client #1 was assessed for a possible fracture to his left middle finger.</p> <p>Record review of Client #1's file showed no consent for restraint procedures related to blood draws.</p> <p>During an interview on 07/02/19 at 12:10 PM, Staff A, Program Area Team Director, acknowledged that Client #1 had no consent for restraint procedures related to blood draws.</p>			W 125			
W 153	<p>STAFF TREATMENT OF CLIENTS</p> <p>CFR(s): 483.420(d)(2)</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as</p>			W 153			

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W 153	<p>Continued From page 2</p> <p>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that an allegation of abuse was reported immediately for one of two Sample Clients (Client #2). This failure resulted in the facility not responding promptly to safeguard Clients from potential abuse, neglect, and mistreatment.</p> <p>Findings included ...</p> <p>Record review of the Initial Inquiry Form, dated 05/05/19, showed that Client #2 had a bruise under his left eye and reported that the Alleged Perpetrator (AP), a staff, had hit him in his eye. It showed that the facility did not notify the Complaint Resolution Unit (CRU) nor local law enforcement of the allegation.</p> <p>Record review of the facility's 5-Day Investigation, dated 05/17/19, showed the following:</p> <ol style="list-style-type: none"> 1. An Event Report completed by an Attendant Counselor (AC) on 05/05/19 that showed Client #2 had reported that the AP, a staff, had hit him in the eye. 2. On 05/05/19 Client #2, when asked about his injured left eye, told the nurse that the AP had hit him in the eye. 	W 153			

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W 153	Continued From page 3 3. On 05/06/19 Client #2 told two different AC's that the AP had hit him in the eye. 4. The Attendant Counselor Manager stated that sometime after the injury was discovered on 05/05/19, and before 05/09/19, that Client #2 had told him that the AP had hit him in the eye. During an interview on 07/02/19 at 12:10 PM, Staff A, Program Area Team Director, stated that staff had been trained on mandatory reporting and should have notified CRU and local law enforcement immediately following Client #2's allegation that he was abused by staff.			W 153			
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to do a thorough investigation of an allegation of abuse for one of six Sample Clients (Client #2) when they did not look into why the incident was not reported to the State Complaint Resolution Unit (CRU) This failure resulted in the facility not understanding all issues related to the incident, prevented the facility from developing an appropriate plan of correction, and potentially put all Clients at risk for abuse. Findings included ... Record review of the facility's 5-Day Investigation, dated 05/17/19, showed that Client #2 had reported to several staff from			W 154			

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W 154	Continued From page 4 05/05/19--05/09/19 that a staff member had hit him in the eye. The investigation did not address why staff had not reported the allegation to CRU until 05/10/19.			W 154			
W 155	<p>During an interview on 07/02/19 at 12:10 PM, Staff A, Program Area Team Director, stated that staff had all been trained on mandatory reporting and should have notified CRU and local law enforcement immediately following Client #2's allegation that he was abused by staff.</p> <p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)</p> <p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a staff, alleged to have abused a Client, was removed from Client care during the course of the facility's investigation into the allegation for one of two Sample Clients (Client #2). This failure potentially put Clients at risk for abuse.</p> <p>Findings included ...</p> <p>Record review of the facility's 5-Day Investigation, dated 05/17/19, showed that on 05/05/19 Client #2 was escorted to his room by the Alleged Perpetrator (AP), a staff, following an incident of Client #2 attacking another staff. According to witness statements, the AP was alone in Client #2's room with him for approximately two minutes. When Client #2 later exited his room staff noticed a dark bruise on his</p>			W 155			

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W 155	<p>Continued From page 5</p> <p>left eye and Client #2 reported that the AP had hit him.</p> <p>Record review of the facility's Plan of Correction, dated 05/06/19, showed that the AP was assigned to work with Clients at the other side of the House from Client #2 on 05/05/19.</p> <p>During an interview on 07/02/19 at 12:10 PM, Staff A, Program Area Team Director, stated that the AP had been reassigned to the other side of the House during the investigation and still cared for Clients.</p>			W 155			

This document was prepared by Residential Care Services for the Locator website

Plan of Correction

DATE OF SOD
July 2, 2019
DATE OF POC
July 15, 2019

RECEIVED

CITATION

JUL 26 2019

Citation: W125 Protection of Clients Rights

- This standard is not met as evidenced by: Residential Care Services
ICF/IID Program
Based on record review and interview, the facility failed to ensure the rights of one of one sample Clients (Client #1) were protected when the facility allowed staff to restrain Client #1 for a blood draw without obtaining written consent. This failure resulted in a violation of Client #1's due process rights.

Facility Analysis of the Processes that led to the Deficiency:

- The need for physical restraint for medical procedures such as arm control for a blood draw is not individually assessed unless it is paired with sedation. In this particular case with Client #1, he did not require sedation for blood draws but did require arm control.
- The use of physical restraints during medical procedures is not documented in a restraint event report and/or restraint log which would coincide with Fircrest's current process for documenting restraints.
- The Interdisciplinary Team was under the impression Client #1's PBSP and PBSP dated 11/09/2018 and PBSP Consent with due process dated 01/10/2019 included arm control that they could implement arm control during medical procedures. However, the function of the behaviors described in the PBSP are different from the function of the behaviors for medical procedures for Client #1.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is July 3, 2019.

Immediate Actions:

- All medical sedation consents were reviewed and an inventory was taken of the individuals that have arm control restraint in their current medical sedation consents.
- That inventory was then sent to the unit Habilitation Plan Administrators to have them clarify if there were individuals that do not have physical restraints included in their medical sedation consents but do require it.
- The Habilitation Plan Administrator and the Healthcare Coordinator began the process for obtaining a more accurate medical sedation consent for Client #1 that includes the use of arm control for blood draws and any other medical procedures he would require any restraints for.

STEPS FOR POC:

- The Quality Assurance Department reviewed all medical sedation consents and took an inventory of all the individuals who that have current physical restraints that are required during medical procedures. The inventory of the individuals that did not have physical restraints was sent out to the unit Habilitation Plan Administrators.
 - Person Responsible: Quality Assurance Department
 - Completion Date: July 3, 2019
- The Habilitation Plan Administrators will review the inventory gathered by the Quality Assurance Department with the Healthcare Coordinator to ensure that all current medical sedation consents

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include the use of physical restraints as appropriate per the client's assessment. If there are physical restraints missing from the consents the Habilitation Plan Administrator and Healthcare Coordinator will obtain due process for the needed restraints.

- Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
 - Completion Date: September 2, 2019
3. The Healthcare Coordinator will review all clients on their caseloads for the need of physical restraints during medical procedures. This will be documented on a tracking sheet and reported to their Interdisciplinary Team to ensure that all needed assessments and due process is obtained to meet the assessed needs of the clients. If it is identified that there is not due process for a physical restraint for medical procedures the Habilitation Plan Administrator and the Healthcare Coordinator will update the client's program and obtain due process prior to their next scheduled procedure.
- Person Responsible: Healthcare Coordinators with oversight by the Resource Nurse-4
 - Completion Date: September 2, 2019
4. The Developmental Disabilities Administrator will conduct a training with the Habilitation Plan Administrators and the Healthcare Coordinators on writing consents for medical sedation that will include the use of assessed physical restraints for medical procedures.
- Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
 - Completion Date: September 2, 2019

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrators will monitor the med run calendar weekly for any scheduled medical appointments to ensure the assessed needs of physical restraints and due process are in place.
 - Person Responsible: Developmental Disabilities Administrators
2. The Quality Assurance Department will review new medical sedation consents as they come to the department to get due process. If the consents are missing information and/or are unclear, the Quality Assurance Department will send them to the Habilitation Plan Administrators and the Healthcare Coordinator for clarification and additional information as per the client's assessed needs.
 - Person Responsible: Quality Assurance Department
3. The Developmental Disabilities Administrators will review the monthly metrics that are completed by the Habilitation Plan Administrators that includes identifying any medical sedation consents that will be expiring that month. All identified medical sedation consents that are expiring will be sent out for guardian approval and due process.
 - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director



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Date

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JUL 26 2019

Residential Care Services
ICF/IID Program

CITATION

Citation: W153 Protection of Clients Rights

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that an allegation of abuse was reported immediately for one of two sample Clients (client #2). This failure resulted in the facility not responding promptly to safeguard Clients from potential abuse, neglect, and mistreatment.

Facility Analysis of the Processes that led to the Deficiency:

- It has been facility practice to have one person call the State Complaint Resolution Unit for an allegation during an active investigation. Our practice is to verify an allegation prior to reporting to the State Complaint Resolution Unit once we have reasonable cause to believe that abuse or neglect has occurred.

Plan for Correcting the Specific Deficiency:

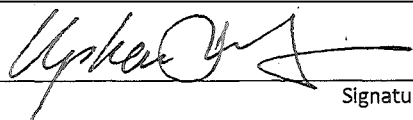
- This portion of the POC start date is May 10, 2019.

Immediate Actions:

- The Program Area Director, Superintendent, and Quality Assurance Director determined that moving forward following notification of an allegation the accused staff will be alternately assigned and the State Complaint Resolution Unit immediately.
- The allegation will be referred for an investigation.
- The verification process will occur following the alternate assignment and call to the State Complaint Resolution Unit.

STEPS FOR POC:

- All on-call management team members will be in-serviced to immediately verify that the State Complaint Resolution Unit was notified by for the individual who reported the allegation and/or facility to call the State Complaint Resolution Unit upon notification of an allegation.
 - Person Responsible: Program Area Director
 - Completion Date: September 2, 2019
- The Developmental Disabilities Administrators will be in-serviced to immediately verify that the State Complaint Resolution Unit was notified by for the individual who reported the allegation and/or facility to call the State Complaint Resolution Unit upon notification of an allegation in the absence of the Program Area Director.
 - Person Responsible: Program Area Director
 - Completion Date: July 31, 2019
- The Residential Services Coordinator will be in-serviced to ensure that there is a State Complaint Resolution confirmation number provided immediately upon notification of an allegation. The Residential Services Coordinator will state to the any employee who asks if they should call the State Complaint Resolution Unit that they are mandatory reporters.



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Date

- Person Responsible: Program Area Director
- Completion Date: August 23, 2019

4. The Attendant Counselors, the nurse, and the Attendant Counselor Manager that were identified to have knowledge of the allegation will be in-serviced on mandatory reporting.

- Person Responsible: Program Area Director
- Completion Date: September 2, 2019

5. All Direct Care Staff will be in-serviced on trained to immediately notify the State Complaint Resolution Unit when they are informed of an allegation regardless of whether they have reasonable cause to believe that abuse or neglect have occurred.

- Person Responsible: Program Area Director
- September 2nd, 2019

Monitoring Procedure for Implementing the POC:

- The Quality Assurance Department will monitor all allegations within one business day to ensure that the State Complaint Resolution Unit was notified. If it is identified that the State Complaint Resolution Unit was not notified following an allegation the Quality Assurance Department will notify the Program Area Director who will address it.

- Person Responsible: Quality Assurance Director



Signature / Title

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7/26/19

Date

Plan of Correction

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CITATION JUL 26 2019

Citation: W154 Protection of Clients Rights

Residential Care Services
ICF/IID Program

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to do a thorough investigation of an allegation of abuse for one of six Sample Clients (Client #2) when they did not look into why the incident was not reported to the State Complaint Resolution Unit (CRU). This failure resulted in the facility not understanding all issues related to the incident, prevented the facility from developing an appropriate plan of correction, and potentially put all Clients at risk for abuse.

Facility Analysis of the Processes that led to the Deficiency:

- The facility was aware of why this allegation was not reported to State Complaint Resolution Unit immediately; however, the facility did not incorporate that information into the investigation information and/or the timeline.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is May 10, 2019

Immediate Actions:

- A five day investigation was started on May 6, 2019.
- The investigation was referred to the Statewide Investigation Unit on May 10th, 2019.
- The Complaint Resolution Unit was notified on May 10, 2019.

STEPS FOR POC:

- An addendum will be completed in regards to the timeline on the investigation to ensure that the investigation accurately reflects all actions that the facility took while investigating.
 - Person Responsible: Program Area Director
 - Completion Date: September 2, 2019
- An addendum will be completed to include the reasoning into why the State Complaint Resolution Unit was not called immediately following the allegation on May 5, 2019.
 - Person Responsible: Program Area Director
 - Completion Date: September 2, 2019
- All on-call management will be in-serviced that following notification of an allegation they will document their actions taken such as but not limited to the accused staff being alternately assigned and the notification to the State Complaint Resolution Unit. This statement will be included in the investigation.
 - Person Responsible: Program Area Director
 - Completion Date: September 2, 2019

Monitoring Procedure for Implementing the POC:


- Upon referral of the investigation the Program Area Director and the Quality Assurance Director will ensure that all pertinent information is include in the referral packet for the investigator.


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Date

- Person Responsible: Program Area Director and Quality Assurance Director
- A member of management that was not a part of the initial referral will review the investigation to ensure that it includes information that is pertinent to the investigation such as but not limited to the documentation from the on-call management individual that took the immediate actions following notification of an allegation.
 - Person Responsible: Program Area Director

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Signature / Title

7/26/19

Date

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DATE OF SOD
 July 2, 2019
 DATE OF POC
 July 15, 2019

CITATION JUL 26 2019	
Citation: W155 Protection of Clients Rights	Residential Care Services ICF/IID Program
<ul style="list-style-type: none"> This standard is not met as evidenced by: <p>Based on record review and interview, the facility failed to ensure that a staff, alleged to have abused a Client, was removed from Client care during the course of the facility's investigation into the allegation for one of two Sample Clients (Client #2). This failure potentially put Clients at risk for abuse.</p>	
Facility Analysis of the Processes that led to the Deficiency:	
<ul style="list-style-type: none"> On Sunday May 5, 2019, the Superintendent was informed of the allegation involving Client #2. The Superintendent was provided with information surrounding the allegation that the accused staff was never alone with Client #2 at any time. This information was gathered by the Residential Service Coordinator from other direct staff that were on the floor. With the information provided the Superintendent did not have reasonable cause to believe that abuse had occurred. The Superintendent removed the accused staff away from Client #2 to the other side of the duplex in an attempt to decrease further agitation for Client #2. On Monday, May 6, 2019 a Habilitation Plan Administrator was asked to complete a five day investigation for documentation purposes. Upon completion of that investigation the Program Area Director reviewed and determined that there was new information regarding the events. The investigation was referred to the Statewide Investigation Unit and reported to the Complaint Resolution Unit, and the accused staff was removed from Client contact. 	
Plan for Correcting the Specific Deficiency:	
<ul style="list-style-type: none"> This portion of the POC start date is May 10, 2019. 	
Immediate Actions:	
<ul style="list-style-type: none"> A five day investigation was started on May 6, 2019. The investigation was referred to the Statewide Investigation Unit on May 10th, 2019. The Complaint Resolution Unit was notified on May 10, 2019. 	
STEPS FOR POC:	
<ol style="list-style-type: none"> All on-call management team members will be in-serviced to immediately remove an accused staff from client contact upon notification of an allegation and to provide the directive to report to Statewide Complaint Resolution Unit. <ul style="list-style-type: none"> Person Responsible: Program Area Director Completion Date: September 2, 2019 The Developmental Disabilities Administrators will be in-serviced to immediately remove an accused staff from client contact upon notification of an allegation in the absence of the Program Area Director. <ul style="list-style-type: none"> Person Responsible: Program Area Director Completion Date: July 31, 2019 The Residential Services Coordinator will be in-serviced that they have the authority to remove a staff from client contact immediately upon notification of an allegation. 	


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- Person Responsible: Program Area Director
- Completion Date: August 23, 2019

4. The Attendant Counselors, the nurse, and the Attendant Counselor Manager that were identified to have knowledge of the allegation will be in-serviced on mandatory reporting.


- Person Responsible: Program Area Director
- Completion Date: September 2, 2019

Monitoring Procedure for Implementing the POC:

1. The Quality Assurance Department will monitor all allegations within one business day to ensure that the accused staff was removed from client care. If it is identified that the accused staff was not removed from client care following an allegation the Quality Assurance Department will notify the Program Area Director who will address it.

- Person Responsible: Quality Assurance Director

This document was prepared by Residential Care Services for the Locator website.

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Signature / Title

7/26/19
Date